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L. Early Discharge Follow-up Visit for Mothers and Newborns. The early discharge follow-up visit for mothers and newborns covered under the provisions of Supplement 1 to 3.1A&B, Item 13.c.A (12 VAC30-50-220.13c.A) shall be reimbursed at the lower of the State Agency Fee Schedule or actual charges. Providers qualified for reimbursement of this service are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The service must be delivered either by the appropriate professional who is an employee of the participating provider or is under contract with the participating billing providers listed above. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health.

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B. Outpatient hospitals that are not enrolled as providers with the Department of Medical Assistance Services (DMAS) which submit claims shall be paid using the DMAS average reimbursable outpatient cost-to-charge ratio, updated annually, for enrolled outpatient hospitals, less five percent. The five percent is for the cost of the additional manual processing of the claims. Outpatient hospitals that are not enrolled shall submit claims on DMAS invoices.

C. Non-enrolled providers of non-institutional services shall be paid on the same basis as enrolled in-state providers of non-institutional services. Non-enrolled providers of physician, dental, podiatry, optometry, and clinical psychology services, etc., shall be reimbursed the lesser of the charges submitted, of the DMAS rates for the services.

D. All non-enrolled non-institutional providers shall be reviewed every two years for the number of Medicaid recipients they have served. Those providers who have had no claims submitted in the past twelve months shall be declared inactive.

E. Nothing in this regulation is intended to preclude DMAS from reimbursing for special services, such as rehabilitation, ventilator, and transplantation, on an exception basis and reimbursing for these services on an individually, negotiated rate basis.

§5. Refund of Overpayments

A. Providers reimbursed on the basis of a fee plus cost of materials.

1. When DMAS determines an overpayment has been made to a provider, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputed in whole or in part DMAS's determination of the overpayment.

2. If the provider cannot refund the total amount of the overpayment within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

3. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, it a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services [the "director"] may approve a repayment schedule of up to 36 months.

4. A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be

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repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

5. If during the time an extended repayment schedule is in effect, the provider withdraws from the Program, the outstanding balance shall become immediately due and payable.

6. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

7. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

8. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

9. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

10. The director's determination shall be deemed to be final on (i) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (ii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iii) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

B. Providers reimbursed on the basis of reasonable costs.

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1. When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputed in whole or in part DMAS's determination of the overpayment.

2. If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, an underpayments discovered by subsequent review or audit shall also be used to reduce the remaining amount of the overpayment.

3. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request an extended repayment schedule.

4. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, it a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of the Department of Medical Assistance Services [the "director"] may approve a repayment schedule of up to 36 months.

5. A provider shall have no more than one extended repayment schedule in place at one time. If an audit later uncovers an additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amount.

6. If during the time an extended repayment schedule is in effect, the provider withdraws from the Program or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

7. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered by the reduction of interim payments to the provider or by lump sum payments.

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8. In the request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

9. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

10. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to §32.1-313 of the Code of Virginia from the date the director's determination becomes final.

11. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

§6. EPSDT.

A. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, reimbursement shall be provided for services resulting from early and periodic screening, diagnostic, and treatment services. Reimbursement shall be provided for such other measures described in Social Security Act §1905(a) required to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan.

B. Payments to fee-for-service providers shall be in accordance with §6. of Attachment 4.19 B the lower of (i) State agency fee schedule or (ii) actual charge (charge to the general public).

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C. Payments to outpatient cost-based providers 4.19(d)) shall be in accordance with §(d) in 4.19 B.

D. Psychiatric services delivered in a psychiatric hospital for individuals under age 21 shall be reimbursed at a uniform all-inclusive per diem fee and shall apply to all service providers. The fee shall be all-inclusive to include physician and pharmacy services. The methodology to be used to determine the per diem fee shall be as follows. The base period uniform per diem fee for psychiatric services resulting from an EPSDT screening shall be the median (weighted by children's admissions in State-operated psychiatric hospitals) variable per day cost of State-operated psychiatric hospitals in the fiscal year ending June 30, 1990. The base period per diem fee shall be updated each year using the hospital market basket factor utilized in the reimbursement of acute care hospitals in the Commonwealth.

§7. Dispute resolution for state-operated providers.

A. Definitions.

DMAS means the Department of Medical Assistance Services.

Division Director means the Director of a division of DMAS.

State-operated provider means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This shall be the sole procedure available to state-operated providers.

The appropriate DMAS Division must receive the reconsideration request within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

C. Informal review. The state-operated provider shall submit to the appropriate DMAS Division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a

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resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable law and regulations.

D. Division Director action. The Division Director shall consider any recommendation of his designee and shall render a decision.

E. DMAS Director review. A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after the receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries shall be final.